

Supplementary

Day 1

Home Photobiomodulation Therapy

Name: _____

Date: _____

1- How would you rate your current **PAIN** level?

On a scale of 1 to 5, with 1 being "No pain" and 5 being "Unbearable pain,"

 No Pain  Mild  Moderate  Significant  Severe

2- How would you rate your current **SWELLING** level?

1=None

2=Mild (slightly noticeable, not bothersome)

3=Moderate (slightly noticeable and slightly bothersome)

4= Significant (significantly noticeable and bothersome)

5=Extreme (very noticeable and extremely bothersome)

 No Swelling  Mild  Moderate  Significant  Extreme

3- How would you rate the difficulty **OPENING** of the mouth?

1=No problem opening my mouth

2=Mild (can open my mouth enough to fit 3 fingers, but it feels a bit stiff)

3=Moderate (can open my mouth enough to fit 2 fingers only)

4= Significant (can open my mouth enough to fit 1 finger)

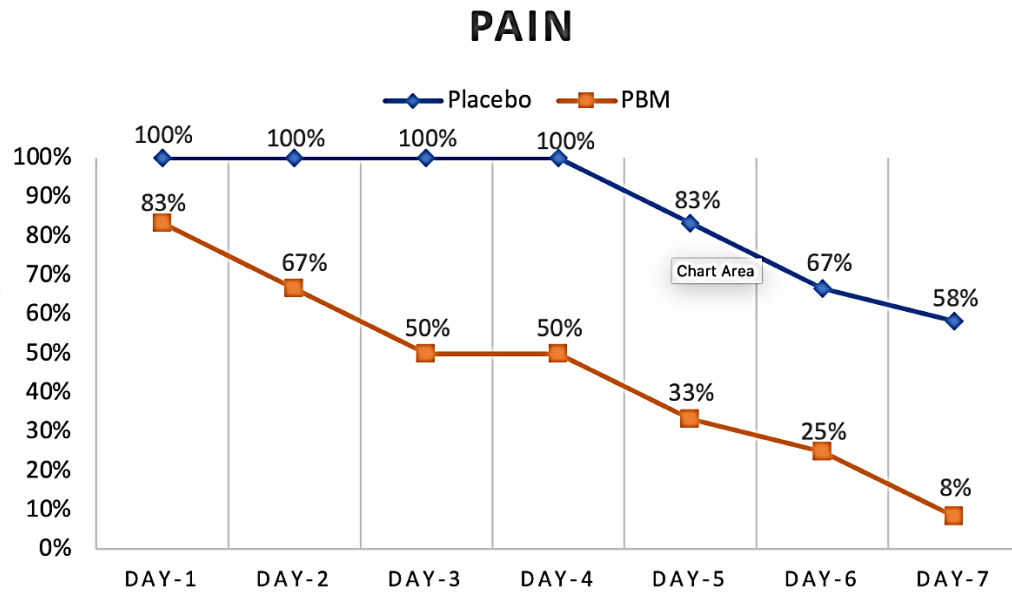
5=Extreme (can NOT open my mouth enough to fit 1 finger)

 No Swelling  Mild  Moderate  Significant  Extreme

4-How many prescribed pain medication did you take?

 None  1 tablet  2 tablets  3 tablets  4 tablets

Figure S1: Patient feedback form used for daily assessment of pain, swelling, trismus, and medication usage during recovery



FigureS2: Pain Reduction Trends Between PBM and Control Group

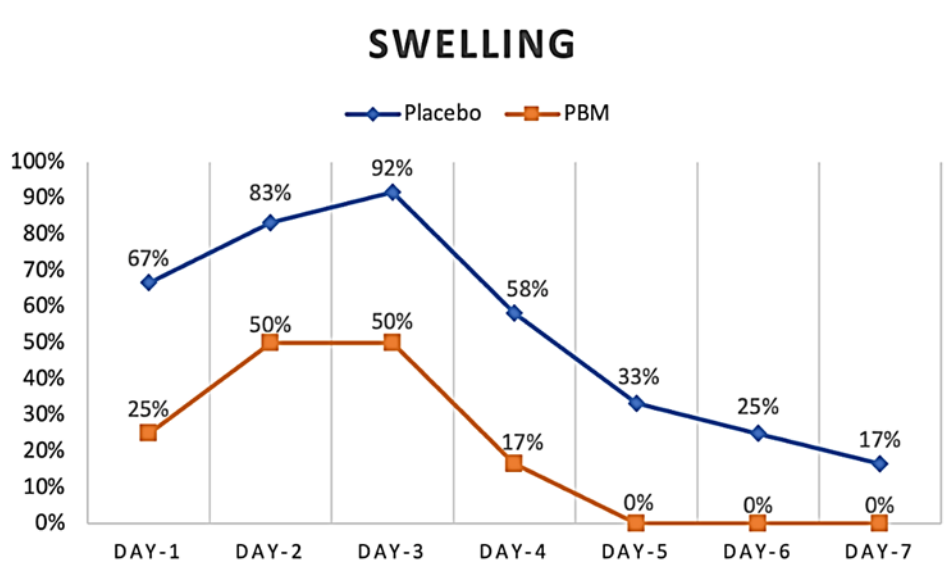


Figure S3: Swelling Reduction Trends Between PBM and Control Groups

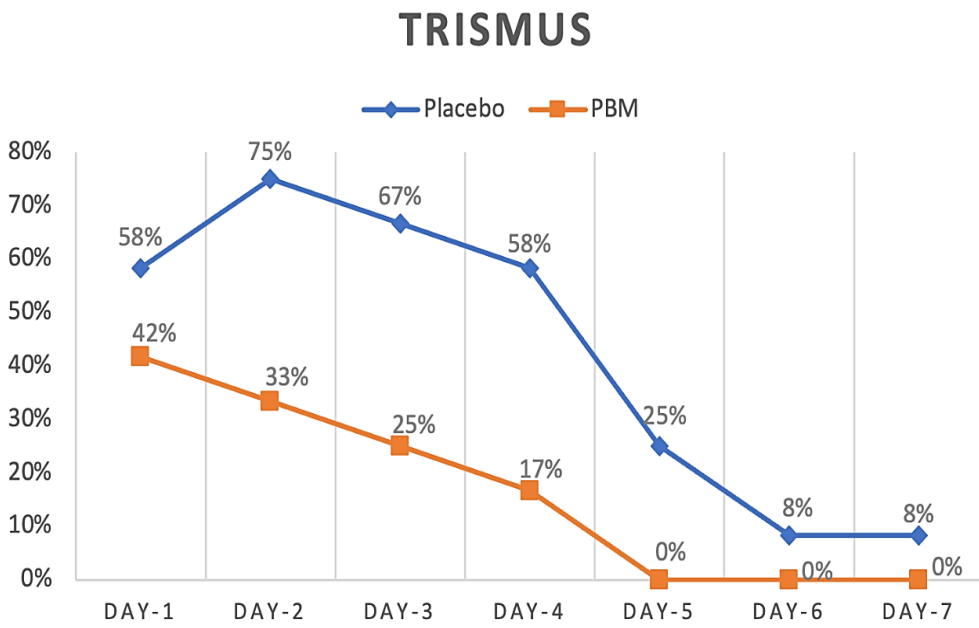


Figure S4: Trismus Recovery Trends Between PBM and Control Groups

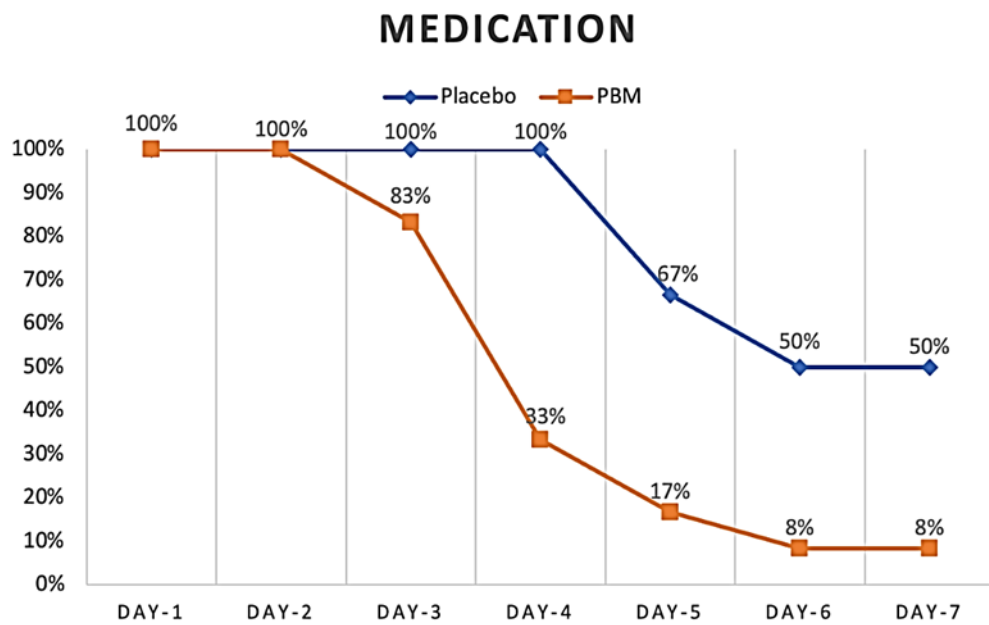


Figure S5: Medication Usage Trends Between PBM and Control Groups